Coding of Suspected, Probable, and Possible Diagnoses

ICD-9-CM Coordination and Maintenance Committee, April 1, 2005

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

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Guidelines in ICD-9-CM

- Inpatient
  - If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", code the condition as if it existed.
    - The basis for this guideline is that diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach correspond most closely with an established diagnosis.

Guidelines in ICD-9-CM

- Outpatient
  - Do not code diagnoses documented as "probable", "suspected", "questionable", "rule out", or "working diagnosis". Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Guideline in ICD-10-CM

- Inpatient and Outpatient
  - Reads the same for inpatient and outpatient based on outpatient rule in ICD-9-CM.

- II.f.1 Use of symptom codes as principal/first listed diagnosis A sign or symptom code …. is not to be used as a principal diagnosis when a definitive diagnosis for the sign or symptom has been established.
- A sign or symptom code is to be used as principal/first listed if no definitive diagnosis is established at the time of coding.

Coding of “Suspected” Diagnoses

- History
  - Rule has existed for more than 40 years
    - Standard Nomenclature of Diseases and Operations [SNDO] 1961
    - ICDA-8 (1968)
    - HICDA-1 (1968)
    - HICDA-2 (1973)
    - ICD-9-CM (1979)

Changing the "Suspected" Guideline

- Discussions
  - NCVHS in 1990's
  - EAB meetings
  - AHIMA annual meeting 10/04
  - Surveys (8/04 - 11/04, 2004)
    - AHA
    - AHIMA CoP

Changing the "Suspected" Guideline

- NCVHS
  - June 1992 Proposed Revision to UHDDS "All substantiated diagnoses that affect the current stay - Code to the highest degree of certainty"
  - Considered it problematic to have different guidelines...believes the outpatient guidelines result in more accurate data and should apply in both settings
  - Further recognized that responsibility for specifying certainty of diagnosis belongs to attending physician and should not be borne by the coder. When qualifying terms are used, coder should seek a definite diagnosis or other clarification from the attending

2004 Survey
AHA and AHIMA Respondents

N=80

Credential	Number	Percent
HIM	60	75%
CFO/Finance	5	6%
President/VP	3	4%
Compliance	2	3%
Nurse	3	4%
Unknown	7	8%

2004 AHA Survey Results

(N=31 Respondents)

Support change	10%
Don’t support change	71%
Uncertain/Split	19%

2004 AHIMA CoP Survey Results

(N= 49 respondents)

Support change	32%
Don’t support change	51%
Uncertain/Split	16%

2004 Combined Survey Results

(Total = 80 Respondents)

Support change	24%
Don’t support change	58%
Uncertain/Split	18%

2004 Survey Results

- Supporting change in guideline
  - Patient labeling
    - Current guideline places coding professional in difficult situation (insurance)
  - Uniformity/consistency in inpatient and outpatient guidelines
  - Easier to teach when you have one set of guidelines for inpatient and outpatient
  - Improve data accuracy

2004 Survey Results (Continued)

- Not supporting change in guideline
  - Basis for guideline still exists - it explains medical necessity, resource use, etc
  - Use of the terms by physicians means it is his/her best clinical judgement that patient has the diagnosis and is being treated
  - Certain conditions not verifiable unless autopsied (e.g., Alzheimer's)

2004 Survey Results (Continued)

- Comments/Concerns
  - Resource utilization in probable cases often exceeds cases where diagnosis is obvious
  - Not coding anything that isn't definitive would leave clinical databases devoid of medical necessity for justifying studies, treatment, denials, etc.
  - Shouldn't make change to make it easier to teach

Immediate and Downstream Impacts

- Immediate downward trend in facility casemix
- Other users (physicians, educators
- No meaningful data comparisons with prior year data possible for several years
- Transition costs /budget neutrality
- Timing of changes: How and when would data users revise their systems to reflect change in guideline

Suggested Alternatives

- Suggested alternatives
  - Create modifier that would account for resource utilization, reimbursement & improve data accuracy
    - Work-up ongoing
    - Certainty of diagnosis (yes, no, uncertain)
    - 6th digit to identify provisional diagnosis
  - Develop additional guidelines
    - Exclude certain diagnoses from the current guideline
      e.g., cancer, epilepsy, multiple sclerosis, seizures
    - Code, if treated

Suspected Diagnoses Internationally

- W.H.O (ICD)
- Australian modification (ICD-10-AM)
- Canadian clinical modification (ICD10-CA)

Suspected Conditions W.H.O. ICD-10

- Volume 2, page 100
  - If, after an episode of health care, the main condition is still recorded as "Suspected", "questionable", etc and there is no further information or clarification, the suspected diagnosis must be coded as if established.
    - Rule in place since ICDA-8

Suspected Conditions ICD-10-AM

- Discharged home
  - Investigations undertaken but no treatment for suspected condition
    - *Assign code for symptoms*
  - Treatment initiated, investigative results inconclusive
    - *Assign code for suspected condition*

Suspected Conditions ICD-10-AM

- Transferred to another hospital
  - If patient transferred with a suspected condition, transferring hospital
    - *Assigns code for suspected condition*

Suspected Conditions (General) ICD-10-CA

- Suspected Conditions/Query Diagnosis

  In effect 2001, amended 2003, 2004

  - If no definite diagnosis has been established by the end of the episode of care, then the information that permits the greatest degree of specificity and knowledge about the condition that necessitated care or investigation should be recorded
    - ***Example:*** Chest pain. Query MI.
    - R07.4 (M) Chest pain, unspecified
    - (Q)I21.9 (3) Acute myocardial infarction, unspecified

Suspected Conditions (General) ICD-10-CA

- Suspected Conditions/Query Diagnosis (Continued)
  - If, after an episode of care, the diagnosis is recorded by the physician as "suspected" and there is no further information or clarification, the suspected condition must be coded as if it were established. Use of the prefix "Q" in these circumstances whenever available.
    - ***Example:*** Query Peptic ulcer
    - (Q) K27.9 (M) Peptic ulcer, unspecified as acute or chronic, without haemorrhage or perforation

Suspected Conditions (Ambulatory) ICD-10-CA

- Coding of suspected conditions not yet ruled out
  - If no definitive diagnosis established by end of ambulatory visit, then the information that permits greatest degree of specificity and knowledge about the conditions that necessitated care or investigation should be recorded as the “main problem”.

Suspected Conditions (Ambulatory) ICD-10-CA

- Coding of suspected conditions not yet ruled out (continued)
  - This may be a sign, an abnormal test result or a symptom.
  - It is presumed that the physician treats the symptoms and continues to pursue a definitive diagnosis...

Suggested Next Steps

- Suggested next steps
  - Work with health care industry to evaluate possible solutions
  - Outreach to users of data (researchers, etc.)
    - "Most important people to decide should be users of information"
  - ??????????